Informed Consent for Audiology Video/Call Telehealth Visit

I understand and agree to each of the following:

☐ 1. The laws that protect the privacy and confidentiality of medical information also apply to telemedicine.

☐ 2. I understand that any information obtained during the telemedicine encounter may be lost due to technical failure. I hold harmless the telemedicine provider and all parties involved in the encounter against any liability, damages, loss, attorney fees and costs of any type due to the loss of information due to a technical failure.

☐ 3. I authorize the use of the information obtained during the telemedicine encounter to be used for treatment, payment and healthcare operations.

☐ 4. I understand that I will not have direct, physical contact with the provider during a telemedicine encounter.

☐ 5. I have the right to withhold and/or withdraw my consent or refuse the use of telemedicine during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise receiving.

☐ 6. I have the right to inspect all information obtained and/or recorded during the course of a telemedicine interaction and may receive copies of this information upon written request.

☐ 7. Providers may have access to any and all relevant information necessary to and/or related to the reason for this encounter. If this service is related to alcohol, drug or HIB status, no information will be re-disclosed unless permitted under 42 CFR Part 2 or state law.

☐ 8. I understand that the telemedicine encounter is voluntary and that a variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time.

☐ 9. It is the role of the provider to determine whether or not my condition being diagnosed and/or treated is appropriate for a telemedicine encounter.

☐ 10. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out-of-state.

☐ 11. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse

☐ 12. A copy of this consent will become a part of my medical record.

I acknowledge that I have read, fully understand and agree to:

- ☐ I consent to the use of telemedicine in my medical care.
- ☐ The Privacy Policy and
- ☐ The Terms of Use (collectively, the “Terms”).

By printing my name here, I am agreeing to conduct transactions electronically, and intend for my electronic signature to be a binding electronic signature on myself and those I am authorized to represent. Further, I understand and acknowledge that I am digitally receiving a copy of the Informed Consent concurrently upon agreeing/signing to print and /or retain a copy.

X _____

Patient's Name

X _____

Patient's DOB